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Citation for published version:

Hendrickx, W, Riveros, C, Askim, T, Bussmann, J, Callisaya, ML, Chastin, S, Dean, C, Ezeugwu, V, Jones, T, Kuys, S, Mahendran, N, Manns, T, Mead, G, Moore, S, Paul, L, Pisters, MF, Saunders, D, Simpson, DB, Tiegies, Z, Verschuren, O & English, C 2019, 'Identifying factors associated with sedentary time after stroke. Secondary analysis of pooled data from nine primary studies.', *Topics in Stroke Rehabilitation*, pp. 1-8.
<https://doi.org/10.1080/10749357.2019.1601419>

Digital Object Identifier (DOI):

[10.1080/10749357.2019.1601419](https://doi.org/10.1080/10749357.2019.1601419)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

Topics in Stroke Rehabilitation

Publisher Rights Statement:

This is an Accepted Manuscript of an article published by Taylor & Francis Group in Topics in Stroke Rehabilitation on 26/04/2019, available online:
<https://www.tandfonline.com/doi/full/10.1080/10749357.2019.1601419>.

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Identifying factors associated with sedentary time after stroke. Secondary analysis of pooled data from nine primary studies.

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Abstract

Background

High levels of sedentary time increases the risk of cardiovascular disease, including recurrent stroke.

Objective

This study aimed to identify factors associated with high sedentary time in community dwelling people with stroke.

Methods

For this data pooling study, authors of published and ongoing trials that collected sedentary time data, using the activPAL monitor, in community dwelling people with stroke were invited to contribute their raw data. The data was reprocessed, algorithms were created to identify sleep-wake time and determine the percentage of waking hours spent sedentary. We explored demographic and stroke related factors associated with total sedentary time and time in uninterrupted sedentary bouts using unique, both univariable and multivariable, regression analyses.

Results

The 274 included participants were from Australia, Canada and the United Kingdom, and spent, on average, 69% (SD 12.4) of their waking hours sedentary. Of the demographic and stroke related factors, slower walking speeds were significantly and independently associated with a higher percentage of waking hours spent sedentary ($p=0.001$) and uninterrupted sedentary bouts of >30 and >60 minutes ($p=0.001$ and $p=0.004$, respectively). Regression models explained 11-19% of the variance in total sedentary time and time in prolonged sedentary bouts.

Conclusion

We found that variability in sedentary time of people with stroke was largely unaccounted for by demographic and stroke-related variables. Behavioral and environmental factors are likely to play an important role in sedentary behavior after stroke. Further work is required to develop and test effective interventions to address sedentary behavior after stroke.

Keywords: Stroke; Cardiovascular Diseases; Sedentary Behavior; Sedentary

Introduction

Stroke is the second most common cause of death and the third leading cause of disability worldwide,^{1,2} with the burden expected to increase during the next 20 years.¹ Almost 40% of people with stroke have a recurrent stroke within 10 years,³ making secondary prevention vital.^{3,4} High amounts of sedentary time have been found to increase the risk of cardiovascular disease,⁷⁻¹³ particularly when sedentary time is accumulated in prolonged bouts.¹⁴⁻¹⁷ Sedentary behavior, is defined as “any waking behavior characterized by an energy expenditure ≤ 1.5 Metabolic Equivalent of Task (METs) while in a sitting, reclining or lying posture”.^{5,6} Studies in healthy people, as well as people with diabetes and obesity, have shown that reducing the total amount of sedentary time and/or breaking up long periods of uninterrupted sedentary time, reduces metabolic risk factors associated with cardiovascular disease.^{8,11,12,14-17} Recent studies have shown that people living in the community after stroke spend more time each day sedentary, and more time in uninterrupted bouts of sedentary time compared to age-matched healthy peers.¹⁸⁻²⁰ Reducing sedentary time and breaking up long sedentary bouts with short bursts of activity may be a promising intervention to reduce the risk of recurrent stroke and other cardiovascular disease in people with stroke.

To develop effective interventions, it is important to understand the factors associated with sedentary time in people with stroke. Previous studies have found associations between self-reported physical function after stroke and total sedentary time, but inconsistent results with regards to the relationship of age, stroke severity and walking speed with sedentary time.^{20,21} These results are from secondary analyses of single-site observational studies, not powered to address associations, and inconsistent in the methods used to determine waking hours; thus making direct comparisons between studies difficult.^{20,21} Individual participant

data pooling, with consistent processing of wake time data, allows novel exploratory analyses of larger datasets with greater power.

By pooling all available individual participant data internationally, this study aimed to comprehensively explore the factors associated with sedentary time in community dwelling people with stroke. Specifically, our research questions were: 1) What factors are associated with total sedentary time during waking hours after stroke? 2) What factors are associated with time spent in prolonged sedentary bouts during waking hours?

Methods

Study design

This was an exploratory data pooling study, in which existing individual participant data were used for secondary analyses. By searches of databases, trial registries and word of mouth, potentially eligible datasets were identified, and authors were invited to contribute their individual participant data and raw activity monitor data. The study was approved by the Human Research Ethics Committee of The University of Newcastle (H-2016-0427).

Study selection

Datasets from studies were included if they met the following criteria;

- (1) Included adults with stroke who were living in the community,
- (2) Measured sedentary behavior using the activPAL monitor (PAL Technologies Ltd, Glasgow, United Kingdom),
- (3) The ethical approval and informed consent for the data collection permitted use of the data for secondary analyses,
- (4) The available data was not influenced by any form of intervention.

Authors of original studies provided de-identified datasets. Factors included in the datasets

were mapped by one author (WH) in consultation with the co-authors. A list of factors of interest was created *a priori* (see Box 1), based on previous research in determinants of sedentary time and consideration of other relevant stroke-related factors.²⁰⁻²⁸ For each dataset, we determined which factors were measured and what measurement instrument was used. Where different measurement instruments were used for the same factor, we sought valid methods to categorize or dichotomize data to facilitate data pooling (see supplementary Box 1 for the conversion methods). Where the original studies included repeated measures, we included data from one time-point only, and used the time-point with the least missing data or at baseline in the case of intervention trials.

Activity monitor data

We chose to only include data on sedentary time that was measured using the activPAL monitor (PAL Technologies Ltd, Glasgow, United Kingdom) because it is highly reliable (Intraclass correlation coefficient 0.79-0.99) and valid (98-100% accuracy) for measuring sedentary time and posture transitions during daily life in people with stroke.²⁹⁻³¹ The ActivPAL uses an inclinometer worn on the anterior side of the thigh to determine if someone is either sedentary (sitting, lying or reclining), standing or walking making it a highly valid and accurate monitor to determine sedentary time.²⁹⁻³¹ A conversion to METs is also possible.²⁹⁻³¹ Event files from all participants were combined into one dataset. To identify waking hours, a custom algorithm was developed based on previously published codes.³² The algorithm aggregated sleep time based on the largest bout of sitting/lying time within a 24-hour period and then aggregated adjacent bouts of sitting/lying time where these bouts were interrupted by short bursts of activity, i.e. to account for getting up to the toilet overnight (see Appendix 1 for more details). Our previous work has found that any three days of monitoring, regardless of weekend or weekday, is sufficient to accurately represent habitual physical

activity over seven days.³³ We therefore included participants with at least three days of valid (>8 hours day) waking wear time.³³ We excluded days in which more than 18 hours of wake time were identified.

Data processing and analyses

From the activPAL data during waking hours, the percentage of total sedentary time and the percentage of waking hours spent in prolonged bouts of sedentary time was determined. Two variables were created for prolonged bouts: percentage of sedentary time in bouts >30 min and percentage of sedentary time in bouts >60 min.^{11,12,14,18} Linear regressions (adjusting for age, gender and study) were conducted to determine the association of individual factors with percentage of total sedentary time, percentage of sedentary time in bouts >30 min and percentage of sedentary time in bouts >60 min. All factors and residuals (from regression analyses) were checked for normality and where needed the appropriate transformations were computed. Factors that were found significantly associated in univariable regressions ($p < 0.05$) were included in the multivariable regressions. We first determined the coverage of factors across studies and then conducted the multivariable regressions with the best coverage of factors across studies and the highest sample sizes. To avoid collinearity, if correlations between independent factors were higher than $r = 0.850$ one factor was removed from the analyses.^{34,35} Both forward and backward stepwise linear regressions were run. Based on the 1:10 rule by Peduzzi et al,³⁶ a sample of at least $n = 250$ was needed to be able to include all the factors we identified *a priori* (Box 1). All analyses were conducted with R statistical software, version 3.3.3 and IBM SPSS statistics version 22.

Results

Participant characteristics

Ten datasets were identified that met the inclusion criteria and we were able to obtain individual participant data from 9 (90%), including n=350 individual participants (Table 1). In all, n=274 (78%) individual participants contributed at least three days of valid activPAL data. There were no differences in demographics between the original (n=350) and final (n=274) sample (Table 2). On average, participants spent 69 (Standard Deviation 12)% of waking hours sedentary, 40 (SD 16)% of waking hours in sedentary bouts >30 minutes and 23 (SD 15)% of waking hours in sedentary bouts >60 minutes. Only age and gender were reported in all studies; other variables were reported in between 3 (33%) and 8 (89%) of included studies (Supplementary Table 1).

Factors associated with total sedentary time

The results of the univariable regression (adjusting for age, gender and study) for percentage of total sedentary time are shown in Table 3. Body mass index ($p=0.048$), stroke severity ($p=0.035$), walking speed ($p<0.001$), walking capacity ($p<0.001$), walking aid use ($p<0.001$), degree of independence in activities of daily living ($p=0.014$), and anxiety ($p=0.028$) were all significantly associated with percentage of total sedentary time. As walking speed and walking capacity were highly correlated ($r=0.897$), and more data were available across the datasets for walking speed, only walking speed was included in the multivariable regression analyses. Only walking speed remained significant in the multivariable regression model ($p=0.001$, see Table 4), which explained 14% of the variance in percentage of total sedentary time.

Factors associated with time spent in prolonged sedentary bouts

The results of the univariable regression (adjusting for age, gender and study) for percentage of sedentary time in bouts >30 min and percentage of sedentary time in bouts >60 min are

shown in Table 3. Body mass index ($p=0.024$ and $p=0.038$), stroke severity ($p=0.019$ and $p=0.016$), walking speed (both $p<0.001$), walking capacity (both $p<0.001$), walking aid use ($p<0.001$ and $p=0.009$), and independence in activities of daily living ($p=0.003$ and $p=0.005$) were significantly associated with percentage of sedentary time in bouts >30 min and percentage of sedentary time in bouts >60 min. Fatigue was significantly associated only with percentage of sedentary time in bouts >60 min ($p=0.044$).

Walking capacity was removed from the multivariable regression because of the high correlation with walking speed. In the multivariable regressions (Table 4), only walking speed was significantly associated with percentage of sedentary time in bouts >30 min ($p=0.001$) and percentage of sedentary time in bouts >60 min ($p=0.004$). For percentage of sedentary time in bouts >30 min, body mass index ($p=0.049$) was also found to be significantly associated. The models explained 19% of the variance in percentage of sedentary time in bouts >30 min and 11% of the variance in percentage of sedentary time in bouts >60 min.

There was a wide range in time since stroke in our dataset (1 to 237 months) and these data were highly skewed. To check whether this confounded results, we categorized the time since stroke into three epochs (1 to 3 months, 3 to 6 months and >6 months) and re-ran the regression models for percentage of total sedentary time using this ordinal variable. This did not change the results.

Discussion

We pooled data from 274 individuals from three countries and found that people with stroke spent on average 69% of waking hours sedentary. Slower walking speed was the only factor independently associated with more total sedentary time, and more time spent in prolonged bouts of sedentary behavior. However, our models accounted for only a small proportion of the variance in sedentary behavior, suggesting that other factors not measured in the

participants included in this study are also important.

Our findings in relation to walking speed are consistent with a previous study which found both slower walking speed, and other measures of poorer physical function (in this case the Stroke Impact Scale) were associated with greater sedentary time.²¹ However, walking speed may also be a proxy measure for general health and co-morbidities.³⁷⁻³⁹ In older people, walking speed is an important predictor of a number of adverse outcomes such as falls, activities of daily living difficulties, disability, institutionalization, comorbidities and mortality.³⁷⁻⁴¹ Further research is needed to determine whether there is a direct causal pathway between slow walking speed and high sedentary time, or if it is a proxy measure of general health. It is possible that interventions aimed at improving the walking abilities of people with stroke might help reduce the total sedentary time and the time spent sedentary in prolonged bouts. However, this premise requires testing in clinical trials.

We found few other factors were independently associated with high sedentary behavior. This is in contrast to previous studies. In older adults *without* stroke, age, gender, education level, living arrangements, body mass index, smoking status, and independence in activities of daily living, were all found to be associated with sedentary behavior.^{22,25-27} In previous studies of people *with* stroke both age and stroke severity were associated with sedentary behavior.^{20,21} In people with multiple sclerosis, both disease severity and physical ability are reported to be associated with high sedentary time.⁴² Taken together, this suggests that the factors associated with high sedentary time may differ between population groups. This is important to consider when developing interventions to reduce sedentary behavior.

In our analyses, the regression models accounted for only a small proportion of the variance in sedentary behavior. It is likely that environmental and behavioral factors may also influence sedentary time in people with stroke, and this should be taken into consideration

when designing interventions to reduce sedentary behavior in this population. Such interventions will need to be carefully developed and include strategies to address both the factors influencing sedentary behavior, and the barriers and motivations to increase light, moderate and vigorous physical activity. Systematic reviews of clinical trials in other populations (healthy and older adults, those with diabetes or obesity) have highlighted the importance of developing interventions specifically targeted to reduce sedentary time, as such programs are more effective for reducing sedentary time compared with interventions that aim to increase physical activity alone.^{45,46} An international consensus framework for sedentary behavior research across all population groups,²³ as well as qualitative research involving people with stroke,⁴⁷ highlight the importance of the environment, psychology (including motivation), education and behavior as determinants of sedentary time. Development of effective interventions to address high levels of sedentary time in people with stroke will need to take all these factors into consideration.

Strengths and limitations

We pooled all available individual participant activity monitor data, and completed a novel exploratory analyses on a large dataset, with sufficient statistical power. We choose this novel data pooling methodology (instead of for instance a meta-analyses) to be able to conduct independent secondary analyses using raw data. This also allowed the inclusion of data from ongoing and unpublished studies. We did not complete systematic literature searches, meaning that it is possible that some potentially relevant datasets were missed. The extensive international collaboration that was the foundation of this study allows confidence that we captured the vast majority of trials that have included activPAL data. The large dataset provides confidence in the results. We re-processed all raw activity monitor files using a custom-built algorithm to consistently and systematically identify sleep-wake time without

manual error.³² We decided to use only data in which the activPAL was used to measure sedentary time. This decision was based on the fact that different activity monitors use different methods to determine sedentary time and movement and therefore combining raw data from different monitors would introduce bias.^{48,49} Two studies have shown the incompatibility of data from different monitors.^{48,49} Only including activPAL data provides confidence in the validity of data between datasets. We acknowledge that this reduced the number of datasets we were able to include. Since the activPAL is highly reliable in the determination of sedentary behaviour it is a commonly used monitor and therefore enabled the inclusion of most of the data that is available.

While we pooled all the available individual participant data, not all factors of interest we identified *a priori* were available. Furthermore, even where the same construct (for example, depression, anxiety, physical ability) was measured, the variability in the outcome measures used necessitated categorizing or dichotomizing data. To facilitate comparability of research findings and future data pooling studies, greater consistency in outcome measurement tools used is required.^{43,44} The international Stroke Recovery and Rehabilitation Round Table group recently conducted a consensus project and have published recommendations for a core dataset for all stroke recovery and rehabilitation trials.⁴³

Though the cut-offs of 30 and 60 minutes, used as an outcome variable for prolonged sedentary time, in their origin are arbitrary they have been used in previous studies on the risk of sedentary behaviour.¹⁴⁻¹⁷ These studies have shown that the risk of cardiovascular disease increases even more when sedentary time is accumulated in these prolonged bouts.¹⁴⁻¹⁷ Therefore these cut-offs provide a standard metric for prolonged sedentary time.

This study included only people with stroke living in the community, and for the most part only those able to walk independently, therefore results have limited generalizability

246 beyond this group.

247 ***Conclusion***

248 We found that variability in sedentary time of people with stroke was largely unaccounted for
249 by demographic and stroke-related variables. Behavioral and environmental factors are likely
250 to play an important role in sedentary behavior after stroke. Further work is required to
251 develop and test effective interventions to address sedentary behavior after stroke.

252 **Disclosure of interest**

253 Authors have no conflicts of interest to declare.

254 ***Sources of funding***

255 Associate Professor English was supported by National Heart Foundation Future Leaders
256 Fellowship (2017-2020), under Grant [number: 101177].

257 Ezeugwu was supported by the Alberta Innovates Clinician Fellowship Award, under
258 Grant [number 201600292], the Clinical Research Innovation Fund, and the Physiotherapy
259 Foundation of Canada through the ACWMS.

260 These funders had no role in study design; in the collection, analysis and interpretation
261 of data; in the writing of the report; and in the decision to submit the article for publication.

262

References

1. Donnan GA, Fisher M, Macleod M, Davis SM. Stroke. *Lancet*. 2008; 371:1612–23.
2. Feigin VL, Forouzanfar MH, Krishnamurthi R, et al. Global and regional burden of stroke during 1990-2010: findings from the Global Burden of Disease Study 2010. *Lancet*. 2014;383:245–254.
3. Johnston SC, Rothwell PM, Nguyen-Huynh MN, et al. Validation and refinement of scores to predict very early stroke risk after transient ischaemic attack. *Lancet*. 2007;369(9558):283-92.
4. Mohan KM, Wolfe CD, Rudd AG, Heuschmann PU, Kolominsky-Rabas PL, Grieve AP. Risk and cumulative risk of stroke recurrence: a systematic review and meta-analysis. *Stroke*. 2011;42(5):1489-94. doi: 10.1161/STROKEAHA.110.602615.
5. Pate RR, O'Neill JR, Lobelo F. The evolving definition of "sedentary". *Exerc Sport Sci Rev*. 2008;36(4):173-8. doi: 10.1097/JES.0b013e3181877d1a.
6. Tremblay MS, Aubert S, et al; SBRN Terminology Consensus Project Participants. Sedentary Behavior Research Network (SBRN) - Terminology Consensus Project process and outcome. *Int J Behav Nutr Phys Act*. 2017;14(1):75. doi: 10.1186/s12966-017-0525-8.
7. Ploeg, van der HP, Chey T, Korda RJ, et al. Sitting time and all-cause mortality risk in 222,497 Australian adults. *Arch Intern Med*. 2012;172:494–500.
8. Neville O, Healy GN, Matthews CE, and Dunstan DW. Too Much Sitting: The Population-Health Science of Sedentary Behavior. *Exerc Sport Sci Rev*. 2010; 38(3): 105–113. doi:10.1097/JES.0b013e3181e373a2.
9. Ford ES, Caspersen CJ. Sedentary behaviour and cardiovascular disease: a review of prospective studies. *Int J Epidemiol*. 2012;41(5):1338-53. doi: 10.1093/ije/dys078.
10. Biswas A, Oh PI, Faulkner GE, et al. Sedentary time and its association with risk for disease incidence, mortality, and hospitalization in adults: a systematic review and meta-

- analysis. *Ann Intern Med.* 2015;162(2):123-32. doi: 10.7326/M14-1651.
11. Bauman, AE, Chau JY, Ding D, Bennie J. Too Much Sitting and Cardio-Metabolic Risk: An Update of Epidemiological Evidence. *Curr Cardiovasc Risk Rep.* 2013;7:293–298 DOI 10.1007/s12170-013-0316-y.
 12. Dunstan, DW, Howard B, Healy GN, Owen N. Too much sitting – A health hazard. *Diabetes Res Clin Pract.* 2012;97(3):368-76. doi: 10.1016/j.diabres.2012.05.020.
 13. Tremblay MS, Colley RC, Saunders TJ, Healy GN, Owen N. Physiological and health implications of a sedentary lifestyle. *Appl Physiol Nutr Metab.* 2010;35(6):725-40. doi: 10.1139/H10-079.
 14. Healy GN, Dunstan DW, Salmon J, et al. Breaks in sedentary time: beneficial associations with metabolic risk. *Diabetes Care.* 2008;31(4):661-6. doi: 10.2337/dc07-2046.
 15. Benatti FB, Ried-Larsen M. The Effects of Breaking up Prolonged Sitting Time: A Review of Experimental Studies. *Med Sci Sports Exerc.* 2015;47(10):2053-61. doi: 10.1249/MSS.0000000000000654.
 16. Chastin SF, Egerton T, Leask C, Stamatakis E. Meta-analysis of the relationship between breaks in sedentary behavior and cardiometabolic health. *Obesity (Silver Spring).* 2015;23(9):1800-10. doi: 10.1002/oby.21180.
 17. Healy GN, Matthews CE, Dunstan DW, et al. Sedentary time and cardio-metabolic biomarkers in US adults: NHANES 2003-06. *Eur Heart J.* 2011;32:590–597.
 18. English C, Healy GN, Coates A, Lewis L, Olds T, Bernhardt J. Sitting and Activity Time in People With Stroke. *Phys Ther.* 2016;96(2):193-201. doi: 10.2522/ptj.20140522.
 19. Paul L, Brewster S, Wyke S, et al. Physical activity profiles and sedentary behaviour in people following stroke: a cross-sectional study. *Disabil Rehabil.* 2016;38(4):362-7. doi: 10.3109/09638288.2015.1041615.
 20. Tieges Z, Mead G, Allerhand M, et al. Sedentary behavior in the first year after stroke: a

- longitudinal cohort study with objective measures. *Arch Phys Med Rehabil.* 2015;96(1):15-23. doi: 10.1016/j.apmr.2014.08.015.
21. English C, Healy GN, Coates A, Lewis LK, Olds T, Bernhardt J. Sitting time and physical activity after stroke: physical ability is only part of the story. *Top Stroke Rehabil.* 2016;23(1):36-42. doi: 10.1179/1945511915Y.0000000009.
22. Chastin SF, Buck C, Freiburger et al; DEDIPAC consortium and on behalf of the DEDIPAC consortium. Systematic literature review of determinants of sedentary behaviour in older adults: a DEDIPAC study. *International Journal of Behavioral Nutrition and Physical Activity* . 2015;12:127 DOI 10.1186/s12966-015-0292-3.
23. Chastin SF, De Craemer M, Lien N, et al; DEDIPAC consortium, expert working group and consensus panel. The SOS-framework (Systems of Sedentary behaviours): an international transdisciplinary consensus framework for the study of determinants, research priorities and policy on sedentary behaviour across the life course: a DEDIPAC-study. *Int J Behav Nutr Phys Act.* 2016;13:83. doi: 10.1186/s12966-016-0409-3.
24. Bampton EA, Johnson ST, Vallance JK. Profiles of resistance training behavior and sedentary time among older adults: Associations with health-related quality of life and psychosocial health. *Prev Med Rep.* 2015;2:773-6. doi: 10.1016/j.pmedr.2015.08.017.
25. Chen T, Narazaki K, Haeuchi Y, Chen S, Honda T, Kumagai S. Associations of Sedentary Time and Breaks in Sedentary Time With Disability in Instrumental Activities of Daily Living in Community-Dwelling Older Adults. *J Phys Act Health.* 2016;13(3):303-9. doi: 10.1123/jpah.2015-0090.
26. Diaz KM, Howard VJ, Hutto B, et al. Patterns of Sedentary Behavior in US Middle-Age and Older Adults: The REGARDS Study. *Med Sci Sports Exerc.* 2016 Mar;48(3):430-8. doi: 10.1249/MSS.0000000000000792.
27. Heseltine R, Skelton DA, Kendrick D, et al. "Keeping Moving": factors associated with

- sedentary behaviour among older people recruited to an exercise promotion trial in general practice. *BMC Fam Pract.* 2015;16:67. doi: 10.1186/s12875-015-0284-z.
28. Sardinha LB, Santos DA, Silva AM, Baptista F, Owen N. Breaking-up sedentary time is associated with physical function in older adults. *J Gerontol A Biol Sci Med Sci.* 2015;70(1):119-24. doi: 10.1093/gerona/glu193. Epub 2014 Oct 16.
29. Taraldsen K, Askim T, Sletvold O, et al. Evaluation of a body-worn sensor system to measure physical activity in older people with impaired function. *Phys Ther.* 2011;91:277–285.
30. Lyden K, Kozey Keadle SL, Staudenmayer JW, Freedson PS. Validity of two wearable monitors to estimate breaks from sedentary time. *Med Sci Sports Exerc* 2012;44:2243-52.
31. Godfrey A, Culhane KM, Lyons GM. Comparison of the performance of the activPAL Professional physical activity logger to a discrete accelerometer-based activity monitor. *Med Eng Phys.* 2007;29:930-4.
32. Winkler EAH, Bodicoat DH, Healy GN, et al. “Identifying Adults’ Valid Waking Wear Time by Automated Estimation in ActivPAL Data Collected with a 24 H Wear Protocol.” *Physiological Measurement.* 2016;37 (10): 1653. 2016; doi:10.1088/0967-3334/37/10/1653.
33. Tinlin L, Fini N, Bernhardt J, et al. Best practice guidelines for the measurement of physical activity levels in stroke survivors. *Int J Rehabil Res.* 2018 Mar;41(1):14-19. doi: 10.1097/MRR.0000000000000253.
34. Vocht, de A. Basishandboek SPSS 22 IBM SPSS statistics 22. Bijleveld April 2014:192-193; 9789055482412.
- 35: Fields, Andy *Discovering statistics using SPSS.* SAGE Publications Ltd, 2009:223-224; 9781847879066.
36. Peduzzi P, Concato J, Kemper E, Holford TR, Feinstein AR. A simulation study of the number of events per variable in logistic regression analysis. *J Clin Epidemiol.*

1996;49(12):1373-9.

37. Viccaro LJ, Perera S, Studenski SA. Is timed up and go better than gait speed in predicting health, function, and falls in older adults? *J Am Geriatr Soc*. 2011;59(5):887-92. doi: 10.1111/j.1532-5415.2011.03336.x.

38. Callisaya ML, Blizzard L, Schmidt MD, et al. Gait, gait variability and the risk of multiple incident falls in older people: a population-based study. *Age Ageing*. 2011 Jul;40(4):481-7. doi: 10.1093/ageing/afr055.

39. Tabue-Teguo M, Le Goff M, Avila-Funes JA, et al. Walking and psychomotor speed in the elderly: concordance, correlates and prediction of death. *J Nutr Health Aging*. 2015;19(4):468-73. doi: 10.1007/s12603-014-0560-y.

40. Donoghue OA, Savva GM, Cronin H, Kenny RA, Horgan NF. Using timed up and go and usual gait speed to predict incident disability in daily activities among community-dwelling adults aged 65 and older. *Arch Phys Med Rehabil*. 2014;95(10):1954-61. doi: 10.1016/j.apmr.2014.06.008.

41. Abellan van Kan G, Rolland Y, Andrieu S, et al. Gait speed at usual pace as a predictor of adverse outcomes in community-dwelling older people an International Academy on Nutrition and Aging (IANA) Task Force. *J Nutr Health Aging*. 2009 ;13(10):881-9.

42. Veldhuijzen van Zanten JJ, Pilutti LA, Duda JL, Motl RW. Sedentary behaviour in people with multiple sclerosis: Is it time to stand up against MS? *Mult Scler*. 2016;22(10):1250-6. doi: 10.1177/1352458516644340.

43. Kwakkel G, Lannin NA, Borschmann K, et al. Standardized measurement of sensorimotor recovery in stroke trials: Consensus-based core recommendations from the Stroke Recovery and Rehabilitation Roundtable. *Int J Stroke*. 2017;12(5):451-461. doi: 10.1177/1747493017711813.

44. Ali M, English C, Bernhardt J, Sunnerhagen KS, Brady M. VISTA-Rehab Collaboration.

More outcomes than trials: a call for consistent data collection across stroke rehabilitation trials. *Int J Stroke*. 2013;8(1):18-24. doi: 10.1111/j.1747-4949.2012.00973.x.

45. Prince SA, Saunders TJ, Gresty K, Reid RD. A comparison of the effectiveness of physical activity and sedentary behaviour interventions in reducing sedentary time in adults: a systematic review and meta-analysis of controlled trials. *Obes Rev*. 2014;15(11):905-19. doi: 10.1111/obr.12215.

46. Martin A, Fitzsimons C, Jepson R, et al. Interventions with potential to reduce sedentary time in adults: systematic review and meta-analysis. EuroFIT consortium. *Br J Sports Med*. 2015;49(16):1056-63. doi: 10.1136/bjsports-2014-094524.

47. Ezeugwu VE, Garga N, Manns PJ. Reducing sedentary behaviour after stroke: perspectives of ambulatory individuals with stroke. *Disabil Rehabil*. 2017;39(25):2551-2558. doi: 10.1080/09638288.2016.1239764.

48. Fanchamps MHJ, van den Berg-Emons HJG, Stam HJ, Bussmann JBJ. Sedentary behavior: Different types of operationalization influence outcome measures. *Gait Posture*. 2017;54:188-193. doi: 10.1016/j.gaitpost.2017.02.025.

49. Kozey-Keadle S, Libertine A, Lyden K, Staudenmayer J, Freedson PS. Validation of wearable monitors for assessing sedentary behavior. *Med Sci Sports Exerc*. 2011;43(8):1561-7. doi: 10.1249/MSS.0b013e31820ce174.

50. Jones TM, Dear BF, Hush JM, Titov N, Dean CM. myMoves Program: Feasibility and Acceptability Study of a Remotely Delivered Self-Management Program for Increasing Physical Activity Among Adults With Acquired Brain Injury Living in the Community. *Phys Ther*. 2016;96(12):1982-1993.

51. Mahendran N, Kuys SS, Brauer SG. Recovery of ambulation activity across the first six months post-stroke. *Gait Posture*. 2016;49:271-6. doi: 10.1016/j.gaitpost.2016.06.038.

Appendix 1. Sleep / Non-wear time identification algorithm

Objective

Identify the single daily longest period of sleep / non-wear activity in order to delineate what is considered as wake period.

Methods

The simple prescription given by Elisabeth Winkler et al. (Winkler et al. (2016)) was used as a starting point.

Recorded data consists of activPAL timestamped events, typified as *sitting/lying*, *standing* and *walking*. Events represent the longest continuous uninterrupted activity of each class. There is one event per step.

It was observed during initial implementation of Winkler's prescription that sleep period patterns for this cohort exhibit a more interrupted pattern, requiring a more flexible approach to correctly identify periods. The algorithm was modified as shown below.

Pseudocode:

Definitions

- **SL:** sleep period. A sleep period consists of a "chain" of "nearby" events, primarily of class *lying*, that accounts for the longest aggregated resting period in a 24hr interval. The meaning of "chain" and "nearby" is made precise through the pseudocode. A sleep period is defined by its start and end times, which must be start and end times of *lying*-class events, and all events encompassed in between. `duration(SL)` is the total accumulated time in *lying* events in **SL**.
- **e1, e2** represent generic *lying* events. A *lying* event carries an "aggregation opportunity window" of length of 12 minutes + 10% of event duration, capped at 45

286 minutes. Longer events have longer opportunity windows to be aggregated into the
287 sleep event chain. The opportunity window of a *lying* event is denoted below as
288 `opp.window(e)`.

- 289 • **Ev** is the list of all events in a 24hr interval for an individual, from noon to noon next
290 day.
- 291 • **LEv** is the list of *lying* events longer than 30 minutes in **Ev**, to be considered for
292 aggregation in the sleep period ("long lying events")
- 293 • **Tlev** is the total time accumulated in long lying events in the day. Used in considering
294 an alternative *chain* of *lying* events for the sleep period.

295 **Algorithm**

296 *Note: how to read pseudocode.* A simplified pseudocode of the algorithm is shown below.
297 `while` and `for each` imply a loop, `if` imply testing a condition; the level of indentation
298 indicates the actions included in the repeating part of the loop or the true outcome of the test.
299 For clarity, abnormal termination conditions are excluded from the algorithm below.

```
Input: Ev
Output: SL

LEv = get lying events longer than 30 minutes from Ev
Tlev = sum of event duration for events in LEv
e1 = find longest event in LEv

A:
initialise sleep chain SL with e1
mark e1 as used
while there are unused events in LEv and SL modified since last pass
    for each unused event e2 in LEv, in descending duration order
        if opp.window(e2) overlaps SL
            add e2 to SL
            mark e2 as used
        endif
    endfor
endwhile

if duration(SL) < 0.4 Tlev and there are unused events in LEv
    e1 = find longest unused event from LEv
    mark all events in LEv as unused
```

```
mark e1 as used
restart from A:
endif
```

Running environment

```
## R version 3.3.3 (2017-03-06)
## Platform: x86_64-redhat-linux-gnu (64-bit)
## Running under: Fedora 25 (Workstation Edition)
##
## locale:
##  [1] LC_CTYPE=en_AU.UTF-8      LC_NUMERIC=C
##  [3] LC_TIME=en_AU.UTF-8      LC_COLLATE=en_AU.UTF-8
##  [5] LC_MONETARY=en_AU.UTF-8  LC_MESSAGES=en_AU.UTF-8
##  [7] LC_PAPER=en_AU.UTF-8     LC_NAME=C
##  [9] LC_ADDRESS=C             LC_TELEPHONE=C
## [11] LC_MEASUREMENT=en_AU.UTF-8 LC_IDENTIFICATION=C
##
## attached base packages:
## [1] stats      graphics  grDevices  utils      datasets  methods    base
##
## other attached packages:
## [1] lubridate_1.6.0 chron_2.3-50
##
## loaded via a namespace (and not attached):
##  [1] backports_1.0.5 magrittr_1.5    rprojroot_1.2    tools_3.3.3
##  [5] htmltools_0.3.5 yaml_2.1.14     Rcpp_0.12.10     stringi_1.1.5
##  [9] rmarkdown_1.5   knitr_1.15.1    stringr_1.2.0    digest_0.6.12
## [13] evaluate_0.10
```

References

Grolemund, Garrett, and Hadley Wickham. 2011. “Dates and Times Made Easy with lubridate.” *Journal of Statistical Software* 40 (3): 1–25. <http://www.jstatsoft.org/v40/i03/>.

James, David, and Kurt Hornik. 2017. *Chron: Chronological Objects Which Can Handle Dates and Times*. <https://CRAN.R-project.org/package=chron>.

R Core Team. 2017. *R: A Language and Environment for Statistical Computing*. Vienna, Austria: R Foundation for Statistical Computing. <https://www.R-project.org/>.

Winkler, Elisabeth A. H., Danielle H. Bodicoat, Genevieve N. Healy, Kishan Bakrania, Thomas Yates, Neville Owen, David W. Dunstan, and Charlotte L. Edwardson. 2016.

“Identifying Adults’ Valid Waking Wear Time by Automated Estimation in ActivPAL Data Collected with a 24 H Wear Protocol.” *Physiological Measurement* 37 (10): 1653.
doi:[10.1088/0967-3334/37/10/1653](https://doi.org/10.1088/0967-3334/37/10/1653).

Demographics

Age

Sex

Employment status

Socio-economic status

Education attainment

Living status

Personal factors

Body Mass Index

Smoking

Levels of moderate to vigorous physical activity

Comorbidities

Environmental aspects

Season of accelerometer data collection

Stroke related factors

Type of stroke

Time since stroke

Stroke severity

Impairments

Upper and lower extremity impairment

Vision impairment

Walking ability

Walking speed

Walking capacity (distance)

Use of walking aids

Physical ability

Self-reported physical function

Independence in activities of daily living

Cognition and mood

Cognitive ability

Fatigue

Anxiety

Depression

301 Table 1. Characteristics of studies that provided data

Author	Country	n	Design	Time since stroke	Walking ability
Dean*	Australia	4	Intervention	< 2 years	Able to walk 10 m independently, no aids
English 2016 ²¹	Australia	48	Observational	> 6 months	Able to walk independently indoors, no aids
Ezeugwu*	Canada	30	Intervention	2-4 months	Able to walk ≥ 5 m independently, no aids
Jones 2016 ⁵⁰	Australia	21	Intervention	No criteria specified; recruitment from general population	Able to walk ≥ 50 m, no aids
Kuys*	Australia	29	Intervention	< 2 months	Able to walk 10 m independently
Mahendran 2016 ⁵¹	Australia	36	Observational	< 4 months	
Paul*	United Kingdom	56	Intervention	Discharged from active rehabilitation	Able to walk independently
Simpson*	Australia	30	Observational	No criteria specified; Participants were recruited from rehabilitation ward	No criteria specified
Tieges 2015 ²⁰	United Kingdom	96	Observational	No criteria specified; Participants with a recent acute hemorrhagic or ischemic stroke were recruited	No criteria specified

*Data from ongoing trials

302 Table 2. Participant demographics

Characteristic	All available data	Pooled data
Sample size, n		
Total	350	274
mean (SD) across studies	39 (25)	30 (15)
Sex, number male (%)	213 (61)	167 (61)
Age, (<i>yr</i>) mean (SD)	66 (14)	66 (13)
Time since stroke (<i>mo</i>) mean (SD)	17 (28)	18 (29)

303 Table 3. Univariate regressions

Factor	Number participants, n (number studies)	Missing data within studies, n (%)	Time spent sedentary		Time spent in sedentary bouts >30 min		Time spent in sedentary bouts >60 min	
			p value	Adjusted R ²	p value	Adjusted R ²	p value	Adjusted R ²
<i>Demographics</i>								
Educational level	52 (3)	0 (0%)	0.564	-0.052	0.709	<0.001	0.845	0.071
Living arrangements	144 (6)	0 (0%)	0.107	0.005	0.524	0.017	0.872	0.028
<i>Personal factors</i>								
BMI	205 (7)	27 (13%)	0.048	0.023	0.024	0.037	0.038	0.031
Smoker	171 (4)	6 (4%)	0.317	0.006	0.971	0.007	0.859	0.018
Comorbidities	147 (4)	0 (0%)	0.359	0.005	0.295	0.016	0.423	0.023
<i>Stroke related factors</i>								
Type of stroke	198 (6)	6 (3%)	-0.067	0.024	0.214	0.033	0.290	0.022
Time since stroke	268 (8)	3 (1%)	0.893	0.010	0.468	0.013	0.254	0.011
Stroke severity	118 (3)	2 (2%)	0.035	0.030	0.019	0.046	0.016	0.045
<i>Walking ability</i>								
Walking speed	195 (6)	6 (3%)	<0.001	0.156	<0.001	0.167	<0.001	0.112
Walking	149 (5)	46 (31%)	<0.001	0.158	<0.001	0.187	<0.001	0.158

capacity (distance)								
Walking aid	216 (7)	4 (2%)	<0.001	0.064	<0.001	0.066	0.009	0.039
<i>Physical ability</i>								
Degree of ADL	197 (6)	4 (2%)	0.014	0.045	0.003	0.065	0.005	0.053
independence								
<i>Cognition and mood</i>								
Cognitive function	145 (5)	37 (26%)	0.864	0.004	0.445	0.019	0.150	0.028
Fatigue	192 (6)	36 (19%)	0.084	0.027	0.101	0.026	0.044	0.020
Mood disorder	194 (6)	8 (4%)	0.235	0.019	0.179	0.016	0.315	0.006
Anxiety	153 (4)	3 (2%)	0.028	0.031	0.079	0.020	0.164	0.003
Depression	175 (5)	8 (5%)	0.055	0.027	0.118	0.016	0.095	0.008

All regressions corrected for age, gender and study. Bolded values indicate statistical significance.

BMI = body mass index, ADL = activities of daily living

307 Table 4. Multivariable regression

Dependent variable		Number participants, n (number studies)	Missing data within studies, n (%)	p value	Unstandardized β (95% CI)*	Standardized β *
Time spent sedentary	BMI	182 (7)	69 (27%)	0.071	0.206	
	Stroke severity	118 (7)	133 (53%)	0.231	0.139	
	Walking speed	195 (7)	56 (22%)	0.001	-0.115 (-0.182 to -0.048)	-0.390
	Walking aid	197 (7)	54 (22%)	0.451	-0.094	
	Degree of ADL independence	197 (7)	54 (21%)	0.532	0.78	
	Anxiety	153 (7)	98 (39%)	0.512	-0.77	
Time spent in sedentary bouts >30 min	BMI	182 (7)	69 (27%)	0.049	0.007 (0 to -0.014)	0.222
	Stroke severity	118 (7)	133 (53%)	0.182	0.151	
	Walking speed	195 (7)	56 (22%)	<0.001	-0.153 (-0.235 to -0.070)	-0.410
	Walking aid	197 (7)	54 (22%)	0.413	-0.100	
	Degree of ADL independence	197 (7)	54 (21%)	0.351	0.113	
Time spent in sedentary bouts >60 min	BMI	182 (7)	69 (27%)	0.110	0.186	
	Stroke severity	118 (7)	133 (53%)	0.132	0.177	
	Walking speed	195 (7)	56 (22%)	0.004	-0.131 (-0.217 to -0.045)	-0.351
	Walking aid	197 (7)	54 (22%)	0.670	-0.054	
	Degree of ADL independence	197 (7)	54 (21%)	0.333	0.122	

Fatigue 192 (7) 59 (24%) 0.441 -0.091

308 All regression were corrected for age, gender and study. All regression analyses included data from: English, Ezeugwu, Kuys, Mahendran, Paul,
309 Simpson and Tiegies. Bolded values indicate statistical significance.

310 *Since forward and backward methods were used for the regressions, not all data is available for the non-significant variables

311

Box 1. Conversion method per variable

Demographics

Age

- In years

Sex

- Male/female

Education attainment

- 3 categories: no high school, high school, college degree

Living status

- Dichotomized to living alone/living with someone

Personal factors

Body Mass Index

- If BMI was not reported it was calculated from height and weight data were available

Smoking

- Dichotomized to yes/no, previous smokers were classified as non-smokers.

Comorbidities

- Categorized in 3 categories; 0, 1 or ≥ 2 comorbidities

Stroke related factors

Type of stroke

- Infarct/hemorrhage/both

Time since stroke

- If not recorded this was calculated based on date of stroke and date of assessment; all data were converted to months.

Stroke severity

- NIHSS

Walking ability

Walking speed

- Five and ten meter walk test converted to meters per second

Walking capacity (distance)

- Six minute walk test, meters

Use of walking aids

- Yes/No

Physical ability

Independence in activities of daily living

- FIM, NEADL, MRS, EQoL or via study specific questions. Dichotomized to independent/not independent in ADLs¹

Cognition and mood

Cognitive ability

- MMSE or the MoCA. Scores dichotomized to either cognitive impaired or not cognitive impaired based on published cut-off scores¹. Cognitive impaired was scored if MMSE ≤ 23 or MoCA ≤ 25 ¹

Fatigue

- CIS-f the FSS or FAS. Dichotomized to either fatigued or not, based on published cut-off scores. Published cut-off scores were not available for FAS so we used cut-off scores developed via expert consensus. Fatigue was scored if CIS-f ≥ 27 ², FSS ≥ 24 ¹ or FAS ≥ 4

Mood disorder

- K10³ and HADS and DHS. Dichotomized to mood disorder yes/no using published cut-off scores. Mood disorder was scored if K10 ≥ 20 , HADS ≥ 8 and DHS ≥ 42 ^{1,3}

Anxiety

- HADS A, dichotomized to anxious/not anxious based on published cut-off scores. Anxiety was scored if HADS A ≥ 8 ¹

Depression

- HADS D and DHS. Dichotomized to depressed or not based on published cut-off scores. Depression was scored if HADS D ≥ 8 or DHS ≥ 42 ¹

313 MMSE=Mini Mental State examination, MoCA=Montreal Cognitive Assessment,
314 FIM=Functional Independence measure, ADL=Activities of Daily Living,
315 NEADL=Nottingham Extended Activities of Daily Living, MRS=Modified Ranking Scale,
316 EQoL=Euro Quality of Life, NIHSS= National Institutes of Health Stroke Scale, CIS-f=
317 Checklist for individual strength, FSS=Fatigue Severity Scale, FAS=Fatigue Assessment
318 Scale, K10=Kessler Psychological Distress Scale, HADS=Hospital Anxiety And Depression
319 Scale, DHS=Depression Happiness Scale.

320 References:

- 321 1. <http://www.rehabmeasures.org>,
322 2. Vercoulen JHMM, Swanink CMA, Galama JMD, Fennis JFM, van der Meer JWM,
323 Bleijenberg G. Dimensional assessment in chronic fatigue syndrome. J Psychosom Res
324 1994;38:383-392.,
325 3. Andrews, G., Slade, T. Interpreting scores on the Kessler Psychological Distress Scale

326 (k10). Australian and New Zealand Journal of Public Health, 25, 494-497 (2001).

327 Table 1. Overview of variables available within the studies

Study no:	1	2	3	4	5	6	7	8	9			
Variable:										Number of studies	Sample size	Missing within studies
Age	x	x	x	x	x	x	x	x	x	9	274	0
Gender	x	x	x	x	x	x	x	x	x	9	274	0
Educational level	x		x	x						3	52	0
Living arrangements	x	x	x	x		x		x		6	144	0
BMI	x	x	x	x	x		x		x	7	205	27 (13%)
Smoker		x	x					x	x	4	171	6 (4%)
Comorbidities	x	x	x	x						4	147	0
Type of stroke		x	x		x	x		x	x	6	198	6 (3%)
Time since stroke		x	x	x	x	x	x	x	x	8	268	3 (1%)
Stroke severity		x						x	x	3	118	2 (2%)
Walking speed		x	x		x	x	x	x		6	195	6 (3%)
Walking capacity (distance)					x	x	x	x	x	5	149	46 (31%)
Walking aid		x	x	x	x	x	x	x		7	216	4 (2%)
Degree of ADL independence		x	x		x	x		x	x	6	197	4 (2%)
cognitive function		x	x			x		x	x	5	145	37 (26%)
Fatigue		x			x	x	x	x	x	6	192	36 (19%)
Mood disorder				x	x	x	x	x	x	6	194	8 (4%)
Anxiety					x		x	x	x	4	153	3 (2%)
Depression					x	x	x	x	x	5	175	8 (5%)

328 Study no: 1:Dean, 2:English, 3:Ezeugwu, 4:Jones, 5:Kuys, 6:Mahendran, 7:Paul, 8: Simpson
329 9:Tieges